Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Anesthesia Alliance of Dallas

Respondent Name
City of Dallas

MFDR Tracking Number
M4-13-3260-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
August 6, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied payment of Code 31575 25, stating "the documentation submitted does not support the level of service. …The code is billed for "fiberoptic intubation" and the provider has marked that box on the anesthesia record… The provider also noted "via glidescope" in the remarks section. …We feel the carrier owes additional payment as outlined on the attached medical fee dispute resolution request, as we have submitted documentation to support this procedure."

Amount in Dispute: $158.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In reviewing the submitted records and based on Medicare Correct Coding Guide Section C, 7, we are standing on our denial of submitted information does not support the level of service of the bill in question. Based on the guidelines this code is for diagnostic procedures and not separately reportable based on the elective procedure; therefore we are continuing to stand on our denial as such."

Response Submitted by: Injury Management Organization, Inc. 4100 Midway Road, Suite 1145, Carrollton, TX 75007

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 21, 2013	31575	$158.30	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information which is needed for adjudication
   - 193 – Original payment decision is being maintained.

Issues

1. Did the requestor support claim with documentation?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the services in dispute as, 16 – "Claim/service lacks information which is needed for adjudication". 28 Texas Labor Code §134.203(b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided…". Review of the submitted CPT code 31575 finds; "Laryngoscopy, flexible fiberoptic; diagnostic. Lay Description; The physician administers a topical anesthetic to the oral cavity, pharynx, and larynx and uses a nasal or oral approach to insert a flexible fiberoptic laryngoscope. The interior of the larynx is examined in 31575". The submitted "Anesthesia Record" shows, "via glidescope" there is no mention of examination of the interior of the larynx as in the code description. The carrier's denial is supported.
2. Requirements of 28 Texas Administrative Code §134.203(b) were not found to be met. Therefore, no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.